STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155126	A. BUILDING _____ B. WING _____	C 02/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO HEALTH AND REHABILITATION CENTER	457 S STATE ROAD 145 FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00085400. Complaint IN00085400 - Unsubstantiated due to lack of evidence. Survey dates: January 26, 27, 28, 31, February 1, 2011 Facility number: 000054 Provider number: 155126 AIM number: 100287850 Survey team: Carole McDaniel RN TC Terri Walters RN Martha Saull RN (January 26, 28, 31, February 1, 2011) Census bed type: SNF/NF: 68 Total: 68 Census payor type: Medicare: 7 Medicaid: 55 Other: 6 Total: 68 Sample: 15 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 2/8/11 by Jennie Bartelt, RN.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Preparation and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provisions of federal and state law. Medco Health and Rehabilitation Center French Lick desires this Plan of Correction to be considered the Center's Allegation Of Compliance. Compliance is effective **February 25th, 2011.** RECEIVED FEB 25 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 252	483.15(h)(1)	F 252		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Stephanie Bentley, Health Facility Administrator | 02/24/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252 SS=C	Continued From page 1 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing stations, hallways and resident bathrooms were maintained in a clean manner for 2 of 2 nursing stations and all hallways on 2 of 2 resident nursing units and a total of 4 of 4 resident bathrooms observed (2 on each of 2 units) in the facility during initial tour of the building. The deficient practice had the potential to affect 68 of 68 residents living in the facility. Findings include: During initial tour of the building on 1/26/11 at 8:45 A.M., the hallways throughout the building were observed. On all walls along all hallways, a carpet material was observed from the baseboard up the wall to hip height. This carpet was a textured surface and in the main hall way across the dining room and on the south unit was a light slate blue color. This same textured carpet was on the north unit in a light rose color. Throughout the building, all the carpet on the lower sides of the walls, was observed to have a worn, pilled, clumped appearance. The worn carpet was also observed to have accumulated stains and dirt throughout.	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 252** 1. Re-education on proper cleaning of the Nursing Stations, facility hallways and Resident bathrooms was provided to all Housekeeping Personnel. The carpeting on the walls was vacuumed and spot treated. Upcoming facility plans are to remove the carpeting from the walls and re-finish the hallways' walls. The Shower Rooms were top scrubbed and "deep cleaned". The Nurses Stations have been stripped, waxed and "deep cleaned". 2. An Environmental Audit was completed in order to identify all environmental / housekeeping areas that need to be addressed and revisions have been made to the, "Deep Clean Schedules". 3. All monthly, "Deep Cleaning Schedules" have been revised to increase routine, "deep cleaning" of the carpeting on the hallways' walls, Residents' bathrooms, shower rooms and Nurses Stations.	

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F 252	Continued From page 2 Also on initial tour of the building, 2 resident bathrooms on the north unit were observed, as well as 2 resident bathrooms on the south unit. All four bathrooms were observed to have a grayish appearance around the edges of the floor, with visible, accumulated dust and dirt. When the bare hand was wiped over the floor in these areas, loose dust and dirt was visible on the hand. The caulking around two of the toilets on north hall had jagged edges with accumulated orange matter and dirt. Also on initial tour, the nurses stations on both the north and south unit were observed to have worn surfaces throughout (behind the nurses station desk) to where the design of the flooring was worn off. Scattered dust and debris was also observed throughout. When the bare hand was wiped over these areas, loose dust and dirt was visible on the hand. During initial tour of the building, the north shower room was observed. The floor was observed to have loose dirt and debris, especially around the edges. Empty pill packets were observed on the floor. Again, when the bare hand was wiped on the floor, loose dirt and dust were visible on the hand. On 2/1/11 at 11:30 A.M. the Housekeeping Supervisor provided a copy of the "Deep Clean Schedule" for the north and south units. This schedule showed the north shower room was to have been cleaned on 1/26/11. The nurses stations were to have been deep cleaned on 1/22/11. Also on the deep cleaning schedule, the observed resident bathrooms were documented to have been deep cleaned on the following dates in 2011: 1/13, due to be done	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 252 continued** 4. The Housekeeping Supervisor and HFA will tour daily in order to address any noted issues as soon as posible or additions to the, "deep cleaning" schedule. Any noted environmental concerns will be forwarded to the Center's Quality Performance Improvement Committee monthly for analysis and review. Any noted non compliance by the Center's Housekeeping Personnel will result in 1:1 re-education with progressive discipline as deemed appropriate. 5. Systemic changes will be completed by 02/25/11.	**02/25/11**

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F 252	Continued From page 3 1/31, 1/13 and 1/14/11. The Housekeeping Supervisor was interviewed at this time also (2/1/11 at 11:30 A.M.). She indicated the cleaning schedule had since been revised, since the facility was made aware of the environmental concerns. On 2/1/11 at 12 P.M., the Housekeeping Supervisor provided a copy of the old cleaning schedule for 2010. She indicated the last time the carpets were cleaned was in December 2010. She indicated last year, 2010, the carpets on the walls were cleaned every 2 months. At this time, a current copy of the "Health Care Services Group, INC. Job to be done: wall washing" was most recently dated 1/1/2000. This policy included but was not limited to "steps to do job " : "...If walls are carpeted, use rug or upholstery cleaner to remove spots."	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This page intentionally left blank**	
F 282 SS=D	3.1-19(f) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician orders were followed for frequency of drawing prothrombin time (PT) and INR (International Normalized Ratio) levels for 1 of 2 residents reviewed for taking Coumadin in a sample of 15. (Resident #63)	F 282		

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F 282	Continued From page 4 Findings include: The clinical record of Resident #63 was reviewed on 1/26/11 at 10:35 A.M. Diagnoses included, but were not limited to, the following: deep vein thrombosis and atrial fibrillation. A lab report for a PT level (used to regulate dose of the medication Coumadin) was completed on 12/21/10 (Tuesday). The results were as follows: PT 55.3, with reference 9.3 - 12.0. The INR value result was 5.2 C (critical lab value), with the reference value of 0.9 - 1.1. The following signed physician order was written on the lab report: "Hold Coumadin x (for) 1 week. Repeat INR Thursday. Review of the 2010 calendar indicated the Thursday date was 12/23/10. This physician order was dated 12/21/10. A "Comprehensive Physician' s Order Sheet for: Telephone/Standing/Clarified Orders " was dated 12/21 (no year specified) and indicated the following: "Hold Coumadin for 1 week. Recheck INR on Tuesday 12/28 D/T (due to) critical INR value." This order was signed by the physician on 12/23/10. A nursing progress note, dated 12/21/10, indicated the following: "Spoke with (physician name) about critical INR value. N/O (new order) to hold Coumadin for 1 week. Recheck INR on Tuesday 12/28 (sic)...." A lab report for a PT level was dated 12/28/10 (Tuesday). Both the PT and INR values were within normal limits. Documentation was lacking in the clinical record	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 282** 1. Resident # 63 was reviewed for discrepancy for Physician's order versus lab draw with no adverse action noted. LPN #2 was provided 1:1 re-education on the importance of complete review and documentation of all MD recommendations including faxed orders. 2. A Coumadin Audit was completed for all Residents that are prescribed Coumadin to ensure that lab frequency and Physician's orders were followed appropriately. No Residents were identified to be affected. 3. Licensed Nursing Personnel were in-serviced on the review / documentation / follow-up of all labs per policy and procedure.	

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F 282	Continued From page 5 of a PT having been done on Thursday, 12/23/10, as the physician ordered. On 2/1/11 at 9 A.M., the DON (Director of Nursing) was interviewed. She indicated she had spoken to the nurse who was caring for the resident on 12/21/10, LPN #2. LPN #2 indicated to the DON, the lab had called her with the critical lab value and she in turn notified the physician via phone and spoke to him. She indicated she had received a telephone order from the physician on 12/21/10 at 10:00 A.M. for the resident to have an INR repeated on Tuesday, 12/28/10. A faxed lab report of the INR from 12/21/10 was faxed to the facility, from the physician's office with his written order on it at 14:26 (2:26 P.M.) for the resident to have a repeat INR on Thursday. The DON indicated this was considered a physician order and should have been clarified with the conflicting order received earlier in the day. 3.1-35(g)(2)	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F282 Continued** 4. Implementation of the Lab / Diagnostic Test Tracking Sheet will be completed by Unit Nurse Managers to ensure that proper review / documentation and follow-up of all Physicians orders are accurate. The review / documentation / follow-up of all labs per policy and procedure as well as the, Lab / Diagnostic Test Tracking Sheet will be forwarded to the Center's Quality Performance Improvement Committee monthly for analysis and review. Any noted non compliance by the Center's Licensed Nursing Personnel will result in 1:1 re-education with progressive discipline as deemed appropriate. 5. Systemic changes will be completed by 02/25/11.	**02/25/11**
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure adequate supervision was provided, physician orders were followed, and/ or	F 323		

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F 323	Continued From page 6 interventions initiated to prevent falls were appropriate for 1 of 5 residents reviewed for falls in a sample of 15. Resident # 22 Findings include: On 1/27/11 at 10:40 A.M., Resident #22's clinical record was reviewed. His current Minimum Data Set Assessment (MDS) dated 11/9/10, indicated a moderate cognitive impairment, zero falls since admission or prior assessment, extensive assistance of 2 or more staff for transfers and ambulation in room. This MDS indicated a range of motion impairment of one upper and lower extremity. Diagnoses included but were not limited to: large right sided CVA (cardiovascular accident) with left sided hemiplegia, right carotid stenosis, and mild cardiomegaly. January 2011 physician orders (before hospitalization of 1/26/11) included but were not limited to: self release seat belt with alarm when up in wheelchair d/t (due to) abnormal positioning(initiation date 9/1/10), when up have resident sitting at nurse's station- staff view(initiation date (8/31/10), high/low bed with one side to wall and in lowest position when abed (initiation date (9/27/10), resident to be up in standard wheelchair with left foot pedal and self release belt alarm (initiation date 10/19/10), 12/23/10-intermittent straight catheterization tid (three times a day). Fall care plan was reviewed on 1/31/11 at 12:30 P.M. This care plan was initiated on 7/16/10 and updated on 1/7/11, and included but was not limited to: Velcro self release seat belt (no date), grab bar to left side (bed), regular wheelchair (10/20/10), rear padding to right side of	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 323** 1. Resident # 22's medical record was reviewed by the Interdisciplinary Team for, "Fall" Care Plan appropriateness and implementation to ensure that all previous and current interventions are appropriate to prevent falls. 2. A 100% Audit of all Residents', "Fall" Care Plans were reviewed for Resident specific appropriateness and implementation to ensure that all previous and current interventions are appropriate to prevent falls. 3. Licensed Nursing Personnel were in-serviced on fall prevention and immediate intervention implementation. 4. New Admissions and any Re-admission into the Center will be assessed for fall risk and or, "individualized" fall interventions. Resident, "falls" will be forwarded to the Center's Quality Performance Improvement Committee monthly for analysis and review. Any noted non compliance by the Center's Licensed Nursing Personnel will result in 1:1 re-education with progressive discipline as deemed appropriate.	

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F 323	Continued From page 7 wheelchair (11/2/10), offer to lay down between meals (no date), and move resident closer to nurse's station (1/3/11). An accident/incident report dated 12/21/10 at 4:15 P.M., indicated,"Rsd's (resident) roommate came down to nrsg (nursing) station and reported his roommate was on the floor. This nurse ran to room found Rsd laying (sic) on mat on floor. Rsd was on R (right) side holding upper torso off mat c (with) R arm. VS (vital signs) were stable. 0 (zero) injuries denied pain, stated he crawled onto mat himself." This report indicated resident was alert. Immediate action taken to prevent falls included to checked function of alarm, and asked resident not to crawl out of bed, but to use call light if he needs assistance. A multi-disciplinary therapy screening tool dated 12/22/10, indicated the resident stated he crawled out of bed to mat and reason was unknown. Intervention was to continue on Occupational Therapy (OT) and Physical Therapy (PT) to improve transfers and ambulation. An accident/incident report dated 12/31/10 at 9:00 A.M., indicated, "Res (resident) roommate came out of room into hall et stated Res was on floor. This nurse entered room et found Resident on back on floor by bed w/c (wheelchair) was on other side of Resident. Res stated, 'I was reaching for call light et slipped out of chair.' res denies any pain or hitting of head. 0 (zero) injuries noted. Res took self to room p (after) breakfast. Res states he took off SRBA (self-release belt alarm) to reach an item on the floor et alarm sounding.. Roommate states SRBA was alarming." This report indicated resident was alert and oriented. Immediate action	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 323 Continued** 5. Systemic changes will be completed by 02/25/11.	**02/25/11**

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F 323	Continued From page 8 taken to prevent further fall was to encourage resident to request assistance and not to remove SRBA. A multi-disciplinary therapy screening tool dated 1/3/11, in regard to 12/31/10 fall, indicated resident slid out of wheelchair looking for call light. Interventions included that resident was to be offered to lie down between meals. Another intervention was that the care plan was updated for a room move closer to nurses station. An accident/incident report dated 1/6/11 at 3:30 A.M., indicated,"Resd (resident) was reaching for BS (bedside) table when res slid out of bed -hitting L (left) side of body on bed. Laceration 1 cm x 0.1 cm L eyebrow..." Immediate action to address fall was to put bedside table closer so resident has in reach and to evaluate room. A follow up report by the Director of Nursing (DON) on 1/6/11, indicated resident rolled out of bed while trying to place urinal on trash can. Therapy department to screen room for safety. A facility transfer sheet dated 1/26/11 at 12:40 P.M., indicated Resident #22 had grand-mal seizures lasting 5 minutes and 2 minutes and was transferred to a hospital. A nursing note dated 1/28/11 at 12:45 P.M., indicated, "Resident returned to facility from (name of hospital) hospital. Transported here via stretcher in ambulance. Arrived accompanied by EMT's. Requires extensive assistance of two with transfers. Has 16 FR (french) 10 cc bulb Foley catheter in place with 950 cc yellow clear urine in bedside drainage bag. Denies pain at this time. B/P (blood pressure) 142/82, P (pulse) 81, T (temperature) 95.8, R (respirations) 18, O2	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This page intentionally left blank**	

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F 323	Continued From page 9 (oxygen) sat (saturation) 92% room air. alert to self confused to place &time. Oriented to room. Call light within reach." An accident/incident report dated 1/28/11 at 3:45 P.M., indicated,"CNA called out D/T (due to) alarm sounding & resident lying on the floor in front of his w/c (wheelchair) in his room." This report indicated resident was alert and oriented to person and confused to time and place. This report indicated resident was standing up on his own from wheelchair without assistance and fell. Immediate action initiated to prevent further falls were to: "Assessed for injury. Assessed vital signs. Assisted resident back into w/c. Reminded resident to ask for staff assist with all transfers." An Interdisciplinary Resident Teaching Record, indicated,"1/28/11, Educated resident to ask for staff assistance with all transfers D/T (do/to) left sided weakness & unsteadiness. When asked resident what to do when he wants to stand up & he now states 'I will get a buddy.' " The accident incident report of 1/28/11, indicated Resident #22 was oriented to person and confused to time and place. An accident/incident report dated 1/29/11 at 8:15 A.M., indicated, "CNA came and got this nurse. Rsd (resident) was in room 119's bathroom. Rsd was in the floor with back against wall. Rsd stated he was trying to go to bathroom. This nurse reminded rsd he had a catheter. 0 (zero) injuries noted neuro (neurological) checks WNL (with in normal limits). This report indicated resident was alert and confused. Immediate action to be taken to prevent falls included: "15 min (minute) checks. Rsd to be first one out of	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This page intentionally left blank**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 dining room and last one into the dining room. Rsd is to be toileted and laid down after meals." On 1/31/11 at 4:10 P.M., the Director of Nursing (DON) was interviewed regarding the fall on 1/28/11, after his readmission to the facility. The DON was made aware of supervision lacking in regard to falls after hospitalization (1/26/11). She indicated, "should be pulled out of room" in reference to previous physician orders of January 2011 (before hospitalization of 1/26/11), to keep resident when in w/c at nurses station in view. On 2/1/11 at 10:40 A.M., during interview with the Director of Nursing (DON) and the Administrator regarding the fall of 1/28/11 and 1/29/11. The DON was made aware of adequate supervision lacking in regard to falls after hospitalization (1/26/11). She indicated she understood what was being said.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This page intentionally left blank**	
F 371 SS=F	3.45(a)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 371		

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	155126	A. BUILDING _____ B. WING _____	C 02/01/2011

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F 371	Continued From page 11 failed to provide sanitary practices, equipment and environment during 1 of 2 tours of the kitchen where 68 of 68 residents' meals were prepared and served. Findings include: The initial kitchen tour on 1/26/11 at 8:15 A.M. was accompanied by the FSS (Food Service Supervisor) who was interviewed regarding concerns throughout the tour. An ice machine was observed, which the FSS indicated was the only facility ice machine. It was positioned 8 inches from the wall adjacent to the entry door to the kitchen with the back of the machine readily visible on entry. The backside and vent portals were covered with a thick sheet of charcoal gray oily dust. Coiled electrical hook up cables were encased in a tube of dust which obliterated the coil surface and made the cable look smooth. The outer cabinet of the ice machine was rusted and corroded. The inner chest had a blue plastic guard running horizontally across the top of a pile of ice and controlling the flow of ice behind it. The guard had shaded gray discolored residue on its surface. It was held in place by two screws. The cap end of one screw was broken off. The FSS indicated it was not known when the screw had broken off or that there were no foreign bodies in the ice. The white plastic/rubber seal around the chest had areas of black matter. The wall behind the ice machine was coated with dust and had dust balls hanging from it. At 8:25 A.M. during the same tour there were 25 of 25 plastic dome lids on a cart near the serving line. They were stacked in a puddle of water and had large amounts of water trapped between them. During interview at this time, Cook #1	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 371** 1. The vent portals of the ice machine, electrical hook up cables to the exterior of the ice machine, and the entire exterior of the ice machine were cleaned. The ice machine was emptied of ice and the, "ice chest" was cleaned. Cook # 1 was re-educated on storing items that were not completely dry. Insulated dome lids were removed from service and sent back through the dish machine with placement on drying rack for air drying until the noon meal was served. Food Service Manager was re-educated on sanitizing solution. The sanitizing solution was poured out and replaced with fresh solution and tested for appropriate strength before usage. The mechanical can opener has been replaced with a new mechanical can opener.	

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F 371	Continued From page 12 indicated they were "Clean from the dishwasher" and stored to be used for the noon meal. At 8:30 A.M. 1 of 1 bucket of sanitizing solution was being used to sanitize food contact surfaces. The solution strength was tested by the FSS. She indicated she should hold the test tape in the solution for 15 seconds and expected it to test the required strength of 200 to 400 ppm. After testing the solution the strength registered 0. The FSS indicated she did not know the test tape manufacturer directed a 10 second dip but that the solution was still not strong enough. The color of the brick red floor did not show through the heavy accumulation of black soil underneath and around prep tables and appliances which were made with raised bottoms to provide cleaning space. The mechanical can opener blade gears were rusty and laden with brown matter. At 8:40 A.M. the FSS indicated the can opener parts were supposed to be run through the dish washer daily. She indicated the scheduled cleaning lists for the entire kitchen area had been checked off as complete, by staff and were up to date. 3.1-21(i)(2) 3.1-21(i)(3)	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 371 Continued** The kitchen was, "deep cleaned". Including all walls (specifically behind the ice machine) and the floor (specifically around and under the prep tables). 2. An audit of the kitchen was completed to identify any areas that need to be addressed and revisions made to the current, "Dining Services Cleaning Schedule". 3. Dietary Personnel were in-serviced on the, "Dining Services Cleaning Schedule", reasoning for placement of dishes in the drying racks and proper procedure for sanitizing solution with return demonstration.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

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F 431	Continued From page 13 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication refrigeration temperatures were maintained according to recommendations of medications housed in the medication refrigerator for 1 of 1 medication rooms observed. This deficient practice had the potential to impact 32 residents who were housed on the North unit, from a total facility census of 68 residents, and had their	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 371 Continued** 4. The current cleaning schedule titled, "Dining Services Cleaning Schedule" will be reviewed daily by the Food Service Manager or designee, weekly by the Administrator and updated as needed. The Food Service Manager will audit utilizing the, "Quick Kitchen Sanitation Rounds" 5 x per week for 3 months with, "random" monitoring thereafter. The HFA will audit utilizing the, "Quick Kitchen Sanitation Rounds" 1 x per week indefinitely. The Registered Dietician will audit utilizing the , "Quick Kitchen Sanitation Rounds" 1 x per month. 5. Systemic changes will be completed by 02/25/11.	**02/25/11**

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F 431	Continued From page 14 medications in this refrigerator. Findings include: On 1/31/11 at 2:10 P.M., LPN#1 was observed reading the temperature in the medication refrigerator in the medication room. LPN #1 read the temperature at 32 degrees. She indicated night shift was responsible to read and document the medication refrigerator temperature. Medications housed in the refrigerator included, but were not limited to, the the following: Pneumonia vaccine, Purified Protein Derivative, Lantus insulin, Aranesp injections, Novolog insulin, Regular insulin, 70/30 insulin and Ativan vials. On 1/31/11 at 2:20 P.M. a current copy of the Refrigeration Temperature Log was reviewed. For the month to date, the following temperature ranges were documented for the medication refrigerator: 32 to 36 degrees. On January 15, "no therm (thermometer)" was documented in the space for logging of a temperature. "Instructions" on the log included, but were not limited to, the following: "...Each day record temperatures for all equipment on the a.m. and p.m. shifts and initial. The refrigerator temperature should be 41 degrees or below...If any temperature exceeds these critical limits, report discrepancies immediately to the Nutrition Services Manager or Supervisor." On 2/1/11 at 9:10 A.M., the Administrator and DON (Director of Nursing) were interviewed. They indicated the temperatures on the refrigerator log were read in Fahrenheit. She also indicated that the policy and procedure will now	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 431** 1. LPN # 1 was re-educated on the manufacturers guidelines for storage temperatures for each medication stored in the medication refrigerator and provided a return demonstration on how to read the thermometer. LPN # 1 was also given guidelines for what to do if the temperature falls outside of, "set" parameters. 2. A revised temperature log has been implemented for all medication and specimen refrigerators in the Center. All Licensed Nursing Personnel have been in-serviced on the usage of the revised temperature log and what to do if the temperature falls outside of, "set" parameters. 3. Center initiated a revised temperature log that follows the Center's stated policy and procedure along with high and low temperature parameters.	

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F 431	Continued From page 15 have parameters for appropriate temperatures. On 2/1/11 at 9:40 A.M., the DON provided copies from the facility copy of the 2011 Lippincott Nursing Drug Guide for the following medications which were stored in the medication refrigerator: all of the insulins indicated to "store drug in the refrigerator or in a cool place out of direct sunlight, do not freeze insulin;" Aranesp: "storage and stability: Store at ...36 to 46 degrees Fahrenheit);" Aplisol (Tuberculin Purified Protein Derivative) "Storage: DO NOT FREEZE: This product should be stored at ...36 to 46 degrees Fahrenheit ...." Pneumovax: "storage and handling ...store unopened and open vials ...36 to 46 degrees Fahrenheit...." Ativan: "...Storage instructions: keep refrigerated at 2 degrees centigrade (C) to 8 degrees C (36 degrees F (Fahrenheit) to 46 degrees F)." Of the 31 days of the month of January 2010, were below the recommended 36 degrees and 1 day was documented as " no therm. (thermometer) " A copy of the Procedure for "Refrigerator/Freezer Temperature Log" dated July 2008 was received from the DON (Director of Nursing) on 1/31/11 at 4:10 P.M. Review of the policy included, but was not limited to, the following: "...promotes the use of Refrigeration Temperature Log as a temperature record for all refrigerator and freezers (sic) units taken twice daily on the AM (sic) and PM (sic) shifts in order to store foods safely and detect problems quickly. Procedures included, but were not limited to, the following: "...record temperatures using the inside thermometer only ...Report discrepancies from standard temperatures immediately to the Nutrition Services Manager or supervisor; Fill in the "Comments/Action box with the action taken	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 431 Continued** 4. Unit Nurse Managers will be responsible to monitor the review of the temperature log Monday through Friday and a designated Department Manager on Saturday and Sunday. Any deficient findings will be forwarded to the DON. Refrigerator temperature logs will be forwarded to the Center's Quality Performance Improvement Committee monthly for analysis and review. Any noted non compliance by the Center's Licensed Nursing Personnel will result in 1:1 re-education with progressive discipline as deemed appropriate. 5. Systemic changes will be completed by 02/25/11.	**02/25/11**

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F 431	Continued From page 16 (i.e., contact maintenance) if the internal temperature is not appropriate...." On 2/1/11 at 9:00 A.M., the Education and Training Supervisor was interviewed. She indicated she had provided a copy of the above policy and procedure to the DON upon her (DON's) request. The Education and Training Supervisor indicated the above policy and procedure was in use currently for the medication refrigerators.	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This page intentionally left blank**	
F 518 SS=D	3.1-25(m) 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure laundry staff were made aware of emergency procedures to turn gas dryer shut off valves and or able to physically turn the valve for 1 of 1 laundry tours in the facility. This deficient practice had the potential to affect 68 of 68 residents residing at the facility. (Laundry Staff #1) Findings include: On 1/31/11 at 1:00 P.M., the laundry facility was toured. The laundry department is housed in a building separate from the facility, across a	F 518		

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F 518	Continued From page 17 parking lot behind the facility. Laundry Staff #1 was interviewed. She indicated the facility had two gas dryers in the department. Two, large, industrial sized dryers were observed side by side at the back door of the department. A standard sized electric dryer was observed placed between one of the large, industrial dryers and the back door. Laundry Staff indicated she didn't know the location of the gas shut off valve for the dryers. During interview on 1/31/11 at 1:30 P.M., Laundry Staff #1 indicated she was made aware of the location of the gas shut off valves. While in the department, Laundry Staff #1 indicated the gas shut off valves for both large dryers were located between the dryers and the wall behind them. The gas shut off valves were located on pipes suspended from the ceiling. One of the valves had a tag labeled "gas shut off." Laundry Staff #1 indicated she would be able to turn the valve off but would need to use a stool, located in the department, to be able to reach it. She demonstrated by getting between the large dryers and the wall. To get behind the large dryers, Laundry Staff #1 had to hoist herself up over the level of the standard dryer, as the standard dryer was placed so close to the large dryer, a person couldn't just walk behind the dryers. Laundry Staff #1 was able to get behind the large dryers by placing her right arm on the standard dryer and her left arm against the large dryers and hoisting herself above the level of the smaller dryer to get behind the large dryers. Once behind the dryers she was unable to reach the shut off valves, suspended from the ceiling. She indicated she would need to use the stool located in the department. In order to get from behind the large dryers, Laundry Staff #1 again hoisted herself over the level of the standard dryer to exit the	F 518	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 518** 1. Laundry Staff # 1 was re-educated on the location of the gas shut off valve for the dryers as well as the Center's Policy and Procedure relating to a fire in the laundry area. 2. An in-service has been provided to Personnel regarding the gas shut off valve for the dryers as well as the Center's Policy and Procedure relating to a fire in the laundry area. 3. Laundry Personnel have been able to give a return demonstration regarding how to shut off all equipment and locate the gas shut off valve in the event of a fire in the laundry area.	

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F 518	Continued From page 18 area. At 1:45 P.M., the Maintenance Supervisor was interviewed. He indicated there was a "back up" gas shut off valve located outside the building. He indicated this "back up" valve could be used when/if one of the large gas dryers was on fire as opposed to using the valve located directly behind the large dryers. The maintenance man indicated in the event there was a fire in the laundry department, the gas dryers should be turned off. Upon request, the maintenance man demonstrated his ability to reach the shut off valves close to the ceiling. The Maintenance man placed the stool behind the large dryers by lifting it over the level of the standard dryer and placing it on the floor behind the large dryers. The stool was able to be opened, despite the large dryer vent tubing located on the floor between the dryers and the wall. The Maintenance man was able to reach both shut off valves. He was however, unable to turn either of the valves off with his hands. He indicated he had been working at the facility for 10 years and the valves had never been turned off. On 1/31/11 at 2:30 P.M., a copy of the current facility Fire Safety Plan, dated April 1995, was provided by the Administrator. This included, but was not limited to, the following: "Procedure in case of fire: Laundry/Housekeeping: Laundry personnel should turn off all laundry equipment, air conditioning, etc...." 3.1-51(b)	F 518	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 518 Continued** 4. Laundry Personnel will be audited monthly to ensure that Laundry Personnel are able to give a return demonstration regarding how to shut off all equipment and locate the gas shut off valve in the event of a fire in the laundry area. Monthly audits regarding the shutting off of all equipment and location of the gas shut off valve in the event of a fire in the laundry area will be forwarded to the Center's Quality Performance Improvement Committee monthly for analysis and review. Any noted non compliance by the Center's Laundry Personnel will result in 1:1 re-education with progressive discipline as deemed appropriate. 5. Systemic changes will be completed by 02/25/11.	**02/25/11**